CHAPTER 1
SECTION 25

HOSPITAL REIMBURSEMENT - OUTPATIENT SERVICES

ISSUE DATE: March 10, 2000
AUTHORITY: 32 CFR 199.14(a)(3)

I. APPLICABILITY

This policy is mandatory for reimbursement of services provided by either network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by TMA and specifically included in the network provider agreement.

II. ISSUE

How are outpatient hospital services to be reimbursed?

III. POLICY

A. When professional services or diagnostic tests (e.g., laboratory, radiology, EKG, EEG) that have CMAC pricing (Chapter 5, Section 2) are billed, the claim must have the appropriate CPT coding and modifiers, if necessary. Otherwise, the service shall be denied. If only the technical component is provided by the hospital, the technical component of the appropriate CMAC shall be used.

B. For all other services, payment shall be made based on allowable charges when the claim has sufficient HCPCS (Level I, II, III) coding information (these may include ambulance, durable medical equipment (DME) and supplies, and oxygen and related supplies).

C. For hospital outpatient facility services, payment shall be paid as billed. For example, revenue code 450 will be paid as billed even if a HCPCS code is shown.

D. Outpatient hospital services including professional services, provided in the state of Maryland are paid at the rates established by the Maryland Health Services Cost Review Commission (HSCRC). Since hospitals are required to bill these rates, reimbursement for these services is to be based on the billed charge.

- END -